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ABSTRACT

A growing body of literature documents the frequency and magnitude of adolescent suicide. Because of the difficulties inherent to the nature of suicide, ascertaining the actual frequency of suicidal completions, attempts, and ideation is extremely difficult. Although there have been many attempts to isolate the correlates and causal factors of suicide, research study results have been inconclusive, and often controversial. Of the many correlational variables in the literature, depression seems most consistently paired with suicidal behavior in adolescents. Although depression has been found to have a relationship to suicide, it has failed to act as an acceptable predictor of suicidal behavior. The Emery Model (1983) postulates a multidimensional approach to the prediction of suicide; it combines a model of adolescent depression by Benson (1979) with the work of developmental theorists Erickson (1959) and Bowlby (1973). Adolescent suicide is seen as involving situational difficulties and developmental forces. Specifically, situational difficulties accompanied by developmental difficulties stimulate or predispose the individual to depression, despair, and self-destructive tendencies. In this way adolescent depression and suicide are seen as a product of the relationship between developmental forces and situational factors. Emery's model also offers an explanation of the different qualitative states which produce parasuicidal and suicidal behaviors, and parallels the work of Beck, et al. (1975; 1985) in pinpointing "hopelessness" or "despair" as the objective state which precedes successful or fully intentioned suicidal attempts. (LLL)

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Toward a Developmental Theory of Adolescent Suicide & Depression

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Running head: ADOLESCENT DEPRESSION & SUICIDE

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Abstract

This paper concerns itself with the relationship between depression and adolescent suicide. An overview of adolescent suicide trends is presented, with a summary of the difficulties inherently involved in studying suicide. Possible causes and correlates to suicide are surveyed. Finally, the relationship of suicide to depression is explored, as well as a developmentally-based model of adolescent depression.

Toward a Developmental Theory of Adolescent Suicide & Depression

The purpose of this literature review is to organize research data on adolescent suicide and depression in an effort to understand the relationship between these two phenomena. To illustrate the importance of studying suicide in the adolescent popuation, an overview of suicide trends is included in this review. In addition, the difficulties inherent in exploring suicide are defined, and many factors which have been postulated in the literature as causations or correlates to suicide are reported. Finally, in an effort to integrate this information, a developmentally-based theory of adolescent suicide and depression is presented, and recommendations are offered for future prevention and research efforts.

Review of Literature

A growing body of literature documents the frequency and magnitude of adolescent suicide. For example, suicide prevention was recently the theme of an issue of The School Counselor (Crocitto, 1991). As Davis, Sandoval, & Wilson (1988) point out, "...the likelihood of secondary school students committing suicide is greater now than at any other time in the past" (p. 559).

Similarly Brent, Kalas, Edelbrock, Costello, Dulcan, & Conover (1986) reported that "...attempted suicide is one of the most common emergencies in child psychiatric practice..." (p. 666). Therefore, it is imperative that school counselors, as well as the many others who live, work and play with this at-risk population, learn about the dynamics of adolescent suicide, and work toward efforts of prevention.

National Trends. To illustrate the severity of the teen suicide problem, White, Murdock, Richardson, Ellis, and Schmidt (1990) reported that the suicide rates in the adolescent population have increased nearly 300% in the past 30 years. In fact, nationally, over 5,000 children and adolescents take their own lives each year (Gispert, Wheeler, Marsh & Davis, 1985). According to Crespi (1990), suicide is now the second leading cause of death for teenagers in the United States.

Maine Trends. A Maine State Department of Human Services report (Shaper, 1983) found that suicide is the third leading cause of death for Maine's children and adolescents. Deaths by suicide in Maine were exceeded only by deaths due to disease and accidents. In fact, more Maine youngsters kill themselves than are killed by others. From 1976 to 1980, for example, there were 50 child and

adolescent deaths from suicide, while 29 youths died by homicide (Shaper, 1983).

Comparing national suicide rates with Maine's, Shaper (1983) documents that Maine youth are keeping pace--and at times surpassing--the nation's youth in this tragic, self-destructive trend. Maine's suicide rate was 4.0 deaths per 100,000 in the 10-14 years-of-age group, while the national rate for this group was 0.9 per 100,000 (a statistically significant difference, according to the D.H.S. report). In the 15-19 years-of-age group, Maine's suicide rate was 8.5 per 100,000, with national rates at 8.7 per 100,000. Suicide deaths in Maine's 5-9 years-of-age group were 0.0 per 100,000--significantly less than the national rate of 1.0 per 100,000. Overall, however, it appears that Maine's children and adolescents are at least as much at risk for suicide as youths nationally.

Quantification Problems. As significant a picture as these statistics paint, many scholars believe than the scale of suicidal activities is much greater than the above data might lead us to believe. For example, several authors have detailed the difficulties and idiosyncrasies with which the reporting of completed suicides seems to be fraught (Allberg & Chu, 1990; Forrest, 1988; Martin & Dixon, 1986; Neiger & Hopkins, 1988). Underreporting or biased reporting of

completed suicides is considered commonplace (Shaffer & Fisher, 1981). For example, "....many 'accidental' deaths, such as those caused by drug over-doses, automobile accidents, firearm accidents, poisonings, and even some homicides, are thought to be suicides...." (Allberg & Chu, 1990, p. 343). Because reporting standards vary from community to community, as well as from state to state, child and adolescent suicide completion rates may well be greater (by a twofold factor) than those reported nationally (Shaffer & Fisher, 1981). Therefore, the number of youths who commit suicide is likely to be greater than national reports indicate.

In addition, research by several authors suggests that many more adolescents attempt suicide than actually complete suicidal acts (Davis, Sandoval, & Wilson, 1988; Sheeley & Herlihy, 1989; Smaby, Peterson, Bergmann, Zenter-Bacig, & Swearingen, 1990; Spirito, Hart, Overholser, & Halverson, 1990; Tishler, McKenry, & Morgan, 1981). These suicide attempts, sometimes known as parasuicides, are considered by many to be considerably more common than completed suicides, with most suicide attempts going unreported. Some estimates suggest that for every completed

adolescent suicide there may be as many as 50 to 100 attempts (Kalafat, 1990).

Further, while suicide attempts are more common than completions, suicidal ideation is even more common (Davis, Sandoval, & Wilson, 1988). In a study of preadolescent school children, for example, Pfeffer, Zuckerman, Plutchick, & Mizruchi (1984) found that suicidal threats and ideation were quite common in normal school children (normal being defined as never having been a psychiatric patient), with 11.9% of the children reporting "suicidal ideas, threats or attempts" (p. 416). Sheeley & Herlihy (1988) suggest that "...because suicidal ideations are common among young people at one time or another, there is no method to measure that number who contemplate or threaten suicide" (p. 89).

In short, because of difficulties inherent to the nature of suicide, ascertaining the actual frequency of suicidal completions, attempts and/or ideation is extremely difficult. It is clear, however, that suicide--in some form--effects many children and adolescents each year. It seems likely that current national statistics, at face value, do not adequately account for the true magnitude of suicide's effect on young people.

Causations & Correlations. Although there have been many attempts to isolate the correlates and causal factors of suicide, research study results have been inconclusive, and often controversial. Robbins (1985) summarized some of the difficulties mental health professionals encounter in trying to understand, predict and prevent teen suicide:

> Clinicians face difficult dilemmas, however, in identifying those who are at greatest risk for medically serious suicide attempts. Many more adolescents make nonlethal attempts than make lethal attempts, and even more express suicidal thoughts. Presumably, not all of these adolescents are at risk for potentially lethal attempts, and we have no clear indices to guide efforts at prevention and treatment. It would be helpful if we could more clearly define clinical and biological features associated with risk for serious suicide attempts. (p. 588)

"....Because of the myriad interrelating, sociopsychological factors associated with an adolescent's decision to end his or her life, it is impossible to pinpoint factors as 'causes'...." (Allberg & Chu, 1990, p. 343-344). Crespi reiterates this point by

stating: "Unfortunately, there is no single predictor of suicide...." (1990, p. 256).

Although clear and immediate causes of suicide have not been established, a number of correlates to adolescent suicide have been identified in the research literature. These factors include: interpersonal conflicts and isolation (Allberg & Chu, 1990); general psychopathology (Allberg & Chu, 1990; Brent et al, 1986; Greuling & DeBlassie, 1980); family disruptions and chaos (Allberg & Chu, 1990; Gispert et al., 1980; Neiger & Hopkins, 1988; Tishler, McKenry, & Morgan, 1981); drug abuse (Greuling & DeBlassie, 1980; Harlow, Newcomb, & Bentler, 1986; Neiger & Hopkins, 1988; Robbins & Alessi, 1985); alienation of youth (Greuling & DeBlassie, 1980); egocentrism (Allberg & Chu 1990); characteriogical complaints and life-long difficulties (Gispert, Wheeler, Marsh, & Davis, 1985); poor school functioning (Gispert et al., 1985; Neiger & Hopkins, 1988); factors inherent in the adolescents' stage of development (Allberg & Chu, 1990; Emery, 1983; Greuling & DeBlassie, 1980; Perrone, 1987); precipitating stress (Gispert et al., 1985; Greuling & DeBlassie, 1980; Kalafat, 1990); preoccupation with death (Pfeffer et al., 1980, 1979; Pfeffer, Soloman, Plutchick, Mizrucki, & Weiner, 1982; Pfeffer et al., 1984); ego identity development and deficits (Bar-Joseph &

Tzuriel, 1990; Pfeffer et al., 1980); copy-cat or cluster phenomenon (Brent, Kerr, Goldstein, Bozigar, Wartella, & Allan, 1989; Neiger & Hopkins, 1988); social skills deficits (Spirito et al., 1990); parent-adolescent communication difficulties (Stivers, 1988); and parental depression (Kazdin, French, Unis, & Esveldt-Dawson, 1983; Pfeffer et al., 1979). Of the many correlational variables in the literature, however, depression seems most consistently paired with suicidal behavior in adolescents (Carlson & Cantwell, 1982; Crumley, 1982; Gispert et al., 1985; Greuling & DeBlassie, 1980; Harlow, Newcomb & Bentler, 1986; Kazdin et al., 1983; Martin & Dixon, 1986; Neiger & Hopkins, 1988; Pfeffer et al., 1980, 1979; Pfeffer et al., 1982; Pfeffer et al., 1984; Robbins & Alessi, 1985; Spirito et al., 1990; Stivers, 1988; Tishler, McKenry, & Morgan, 1981).

The Role Of Depression In Suicide. In a recent summary of the literature, Allberg & Chu (1990) stated that "one of the key symptoms that has been found in adolescents who have attempted or completed suicide is that of depression" (p. 344). However, there is disagreement about the relationship between adolescent suicide and depression. Gispert et al., (1981) reported that:

> ...controversy surrounds the etiology of suicide, particularly suicide among the young. Also, there is much uncertainty in

> the literature as to whether suicidal adolescents even evidence vegatative symptoms of depression (sleep disturbances, appetite disturbances, vague somatic complaints) or even depressive equivalents (school truancy or substance abuse...(p. 86-87)

Gispert et al. (1985) summarize:

> Despite important advances in the definition and study of depression in children and adolescents over the last decade...the relationship between depression and suicide remains unclear. It is accepted that depressed patients are at risk for suicide. Less well established is that suicidal patients, especially adolescents, are depressed. (p. 754)

Several studies have been published which indicate a mixed review of the importance of depression to suicide. For example, Crumley (1979), with a highly select group of suicidal adolescent psychiatric patients, found that Axis I disorders (including major depressive episodes and mood) characterized the diagnoses of subjects in that study. A similar correlation between suicidal ideas and childhood depression was noted by Pfeffer et al.(1979). With a similar sample, another study by Pfeffer et al. (1982) found a "...slight positive relationship between suicidal potential and major

depressive disorder, adjustment disorder, and specific developmental disorder...." (p.568). Their data suggest, however, these diagnoses are not good predictors of suicidal behavior.

In a study of 102 children and adolescents, Carlson & Cantwell (1982) reported that 63% of their depressed subjects were suicidal, while 34% of their suicidal subjects reported no depression. To account for the disparity between suicidal feelings and depression in some of their subjects, the authors had three hypotheses: 1) the subjects weren't telling the truth about their depression, 2) a suicide attempt "brought some relief from both the suicidal urge and the depression or the depressive episode remitted" (p. 366), or 3) desiring death comes from some other quality than depression. Again, although depression was found to have a relationship to suicide, it failed to act as an acceptable predictor of suicidal behavior.

Beck Model--Hopelessness: Data from two studies by Beck (Beck, Kovacs & Weissman, 1975; Beck, Steer, Kovacs, & Garrison, 1985) suggest that "...hopelessness is the key variable linking depression to suicidal behavior...." (1975, p. 1146)

> The main thrust of Beck's [sic] argument is that the suicidal behavior of the depressed patient is derived from specific

> cognitive distortions: the patient systematically misconstrues his experiences in a negative way and, without objective basis, anticipates a negative outcome to any attempts to attain his major objectives or goals. (Beck, 1975, p. 1147)

The results of the initial study in 1975 indicate that hopelessness is a better indicator of suicidal intent than depression.

In a later longitudinal study (subjects were followed from 5 to 10 years), Beck et al. (1985) reported that high hopelessness scores correctly identified 91% of the eventual suicides which were committed by study subjects. It should be noted that the subjects in the two Beck studies were adult psychiatric patients. Although it is not certain that hopelessness will yield the same results with a non-hospitalized adolescent population, the results of the 1985 study suggest that hopelessness may prove to be an effective predictor of suicidal intent.

Emery Model. In an article on adolescent depression and suicide, Emery (1983) pointed out that in our efforts to prevent suicide, we often see the symptoms of depression used as indicators of suicide. Thus, we have the tendency to act as though there were a casual link between depression and suicide. Emery suggests that:

> ...it is wise...not to assume as close an interrelatedness

> between suicide and depression as has been commonly taken for granted. It seems that there is a difference in substance between, on the one hand, a mood which is a subjective experience although it has behavioral characteristics, and on the other hand, acts which involve motility...(p. 247)

Emery believes that we need to consider depression and suicide as related in some complex way, but also relatively independently. By looking at suicide and depression in this way, he postulates a "multidimensional approach" which combines a model of adolescent depression by Benson (1979) with the work of developmental theorists Erickson (1959) and Bowlby (1973).

Emery discusses Benson's "four syndromes of depression in adolescents" (p. 251) as follows: The first stage of adolescent depression is called "acute depression" (p. 251). This depression, which corresponds to "Bowlby's 'of human sorrow' prototype" (p. 255), tends to be less serious than the later stages of depression. Emery states: "When I refer to acute depression as benign, I mean that the course is reversible" (p. 251).

The second stage of this adolescent depression model, called the "chronic depression," (p. 255) is likely to begin in middle adolescence.

During this time, depression is characterized by "...crying, sadness, searching behavior, and relative resistance to accepting comfort..." (p. 255) He suggests that, at this stage, the depressed adolescent is displaying the "...process of separation more than with any serious defect in the individual...." (p. 255). The behavior is likely to be that of protest against "loss of the love object (p. 255).

The third stage of adolescent depression is that of "despair." It is common in middle to late adolescence, and is likely to include the "behavioral equivalents of depression" (p. 251). Such teens commonly display delinquency, somatic complaints, and sudden changes in behavior (i.e., vegetative signs of depression). Emery summarizes:

> Risk-taking behavior is an integral ingredient and may take a variety of forms, from sexual acting out to daring acrobatic acts or parasuicidal behavior. There is more anxiety and increased anger in these youngsters....The clinical picture shows what is described as hysterical features. (p. 256)

Poor grades, defensiveness, and troublesome behavior in the adolescent often mark this stage.

"Detachment" is characteristic of the fourth, and most seriously suicidal, stage. During this stage, depression may become "masked" (p. 251).

> ...the youngster may appear normal in his behavior and nihilistic in his thinking. The cognitive development may be such as to allow a rationalization for his detachment or alienation. Isolation may appear to be more prominent.... (p. 256)

The isolation which the adolescent seeks can be both a way of cutting herself/himself off from others, and cutting off his/her own feelings. This is the stage in which suicide may appear "out of the blue" (p. 256).

Integration. The Emery model for understanding adolescent suicide and depression is useful in several ways. First, Emery's theory takes into account what is known about adolescent development in its explanation of the relationship between suicide and depression.

> Instrinsic maturational factors propel the organism through stages, and together with the situational factors, shape the development of the individual (p. 257)....It does seem that as

> the youngster goes through these interlocking and interlapping phases, there is a process of synthesis which tends to consolidate these psychological developments in the direction of a functioning, healthy personality or in the direction of perpetuating psychopathology to the point, at times, of the formation of a negative identity. (p. 256)

Adolescent suicide is seen as involving situational difficulties and developmental forces. Specifically, situational difficulties (e.g., school failure, loss of loved one, family problems, etc.) accompanied by developmental difficulties (such as failure to resolve major developmental life crises) stimulate or predispose the individual to depression, despair and self-destructive tendencies. In this way, adolescent depression and suicide are seen as a product of the relationship between developmental forces and situational factors.

Second, Emery's model is helpful in that it explains the existence of the myriad of correlates to suicide (i.e., situational factors) which have been discussed earlier in this review. For example, in Emery's view, "acute depression" may be brought on, or fed by, any of a number of these correlates or situational factors. If those initial factors are not alleviated or become

exacerbated, stage two ("chronic depression") may begin, and so on.

Third, Emery's model is useful in that it acknowledges and explains the varying natures of lethal and nonlethal suicide attempts. Emery outlines the characteristics of suicidal behavior at each stage, as follows:

> In the course of the experiencing of despair, impulsive self-destructive behavior is more likely than in the course of the phase of detachment when behavior is more deliberate. Despair breeds impulsive suicide while detachment results in more deliberate suicidal behavior. (p. 256)

From this it follows that the despair period may breed suicidal ideation (e.g., talking and thinking about suicide) and parasuicidal behavior (e.g., swallowing a handful of aspirin), while behavior in the detachment phase is more characteristic of the premeditated and lethal attempts at suicide (e.g., shooting). This theory gives plausible explanation for the disparities in anecdotal accounts of suicide, with some suicidal attempts appearing as dramatic risk-taking, yet not lethal, gesture-like cries for help, while others appear to be purposeful, deadly, and often, "out of the blue."

Support for Emery's notion of a continuous, developmental model of suicidal activity is found in the work of Brent et al., (1986). In their study with an adolescent population, the authors concluded that their data "...supports the view that suicidal behavior and suicidal ideation are continuous manifestations of the same phenomenon...." (p. 672). Brent et al. found that suicidal activity begins with 1) suicidal ideation, leading to 2) depression, 3) hopelessness and parasuicidal behavior, and then to 4) lethal and ultimately successful suicide attempts. These stages clearly corresponds with Emery's model.

Further support for Emery's view is found in the work of Beck et al. (1975; 1985). Emery postulates that the fourth stage of this model, "despair"--which, according to Webster's Seventh New Collegiate Dictionary (Merriam, 1970) means "to lose utter hope or a cause of such a loss" (p. 224)--is the most lethal stage of suicidal behavior. This loss of hope is consistent with the conclusion of Beck et al., (1979; 1985) that "hopelessness" is the best predictor of eventual suicide. Emery describes the "detachment" phase as "nihilistic" (p. 251), a term clearly related to the Beck et al. conception of hopelessness.

Overall, Emery's theory is useful is several ways. It allows for, and helps to interpret, the existence of many correlates to suicide. In addition, it provides a framework for viewing the role of depression in suicide, and it acknowledges--and is rooted in--developmental theory. Perhaps its most attractive offerings, however, are its explanation of the different qualitative states which produce parasuicidal and suicidal behaviors, and its seeming parallels with the work of Beck et al. (1975; 1985) in pinpointing "hopelessness" or "despair" as the objective state which precedes successful or fully-intentioned suicidal attempts.

Conclusion

As we have seen, adolescent suicide is a problem which affects many people in many different ways. Much work has been done in an effort to sort out the causes and correlations of suicide in this age group, but a simple and clearly proven cause-effect relationship has not been found.

Theories such as those offered by Beck et al. (1979) and Emery (1983) provide us with interesting and potentially useful conceptualizations for understanding the relationship between depression and suicide in adolescents, and seem suitable places to

start with in regard to future research and prevention efforts. Possible research questions include: Are parasuicidal and suicidal attempts part of the same continuum of behavior? Is there a progressive, stage-like pattern to depressive and suicidal behavior? Do adolescents and children display vegetative symptoms when depressed? Is hopelessness or despair a good indicator of later suicidal behavior in an adolescent population? What are the treatment possibilities for loss of hope?

Clearly, there is still much to be learned about the relationship between adolescent depression and suicide. From the data explored in this review, it is the opinion of this author that there is not enough conclusive evidence to warrant applying the theories presented in this review to prevention efforts in a general counseling practice. This is perhaps an odd conclusion, during a period in which public schools are increasingly implementing suicide prevention programs (Shaffer et al., 1988). Sheeley & Herlihy (1989) conclude: "Thus, the duty to warn and protect is clearly an ethical obligation...." (p. 90). It is the contention of this author, however, that it is often impossible to "warn" and "protect" from that which we do not conclusively understand and cannot accurately predict.

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